# The role of countertransference in contemporary psychiatric treatment

The concept of countertransference has undergone considerable change since Freud first proposed it in 1910. At that time, he conceptualized it as an obstacle to be overcome. In essence, it was viewed as the doctor's transference to the patient. The doctor unconsciously experienced the patient as someone from his/her past.

However, as the term evolved in clinical usage, its meaning was broadened. The implication suggested by P. Heimann in 1950[1] was that the doctor's total emotional response to the patient is not simply an obstacle or hindrance based on his/her own past, but rather an important tool in understanding the patient's unconscious world.

D.W. Winnicott[2], writing at about the same time as Heimann, also argued for the usefulness of countertransference. He noted that therapists often react to patients in the same way that others do. Certain patients can be so contemptuous that everyone with whom they come in contact, including the therapist, may respond with negative or even hateful feelings. He made the point that this hateful reaction had much less to do with the therapist's own personal past or intrapsychic conflicts. Rather, it reflected the patient's behavioral strategies and the need to evoke specific reactions in others.

Clinicians of all persuasions accept today the idea that countertransference can be a useful source of information about the patient. However, at the same time, the therapist's own subjectivity is involved in the way the patient's behavior is experienced. Hence, there has been a movement in the direction of regarding countertransference as a *jointly created* phenomenon that involves contributions from both patient and clinician. The patient draws a therapist into playing a role that reflects the patient's internal world, but the specific dimensions of that role are colored by the therapist's own personality[3].

The implications are that the patient may project some aspects of his/her internal world into the therapist, and the therapist may react as though he/she has been "taken over" by the patient. Generally known as projective identification[3,4], this mechanism is pervasive in clinical practice, whether the clinician is a psychotherapist or not. It can be understood in three steps: a) an aspect of the patient's self (or an internal representation of others) is projectively disavowed by the patient and unconsciously placed in the therapist; b) the patient exerts interpersonal pressure that coerces the therapist to experience or unconsciously identify with what has been projected; and c) the recipient of the projection processes and contains the projected contents and helps the patient take back, in modified form, what has been projected.

A simplified clinical example of this phenomenon is the following: the patient may have had a harsh and critical father and carries an internal representation of that father within. If he has a male therapist, he may experience him as having similar characteristics when the therapist asks him to say whatever comes into his mind. The patient, who may hear the therapist's request as an order, may become defiant and say that he is not going to talk about what is in his mind. The therapist may at first be calm, but over time grow irritated with the patient's refusal to cooperate with the process. At some point, he may say: "You are not doing what I have asked you to do!". In this second step of projective identification, the therapist has become very similar to the patient's own father and produces a reaction in the patient, who might reply: "I feel you are scolding me. I don't think you are behaving very professionally". In this third step of the process, the patient himself takes back the hostile internal representation of his father after the therapist has expressed his irritation.

The most important point in this example is that projective identification and countertransference often reflect the patient's attempt to evoke feelings in the therapist that the patient cannot tolerate. The patient attempts to nudge the therapist into behaving in a manner that corresponds to what the patient is projecting. Most clinicians would argue that the therapist is inevitably influenced to some degree by whatever the patient is projecting. There is an ever-present risk that the therapist may confuse his/her own feelings with those of the patient. It is important to clarify in this context that the countertransference jointly created by patient and doctor will vary from one clinician to the next. The therapist's experience of important people in his/her life has also been internalized and interacts with whatever is projected into him/her by the patient. Hence, there are variations from one therapist to another depending on how the combination of the patient's projection and the therapist's internal world interact.

When the therapist responds in a way that reflects influence by the patient's projection, this is often referred to as a countertransference enactment. In other words, the therapist is enacting something that originated in the internal world of the patient. It is generally accepted that the countertransference enactment may have valuable aspects that can be discussed between patient and therapist.

In the Menninger Treatment Intervention Project[5], audiotaped transcripts of psychotherapy with patients who had borderline personality disorder were studied by a team of researchers, revealing numerous examples of these enactments. For example, in one case, the patient repeatedly threatened to quit the therapy. The therapist responded by verbally pursuing the patient and insisting that he felt she was not ready to terminate. So, there was a partial transference gratification produced by the countertransference enactment by the therapist: the patient experienced it as a sign that the therapist cared about her and was engaged in trying to help her find a way to continue treatment. The countertransference enactment also sent the message that the patient was treatable and could be helped by the process. The patient ultimately stayed for two years of therapy and was rated by independent assessors as considerably improved.

In recent years, with the demise of the "blank screen" stereotype, virtually all clinicians acknowledge that occasionally mak-

ing self-disclosures of what they are feeling can be helpful to the treatment process. It is common knowledge that therapists are disclosing things about themselves whenever they are choosing to comment on a particular aspect of what the patient is saying. However, these inadvertent self-disclosures are not the same as specific technical interventions designed to allow one to use the countertransference constructively.

In *some* treatments with *some* patients, self-disclosures may be constructive. Therapist's feelings are often apparent to the patient and to deny them would be disingenuous. If the patient sees that the therapist is upset and asks "Are you angry?", the therapist might, for example, say "I think you are accurately detecting some of my feelings, and I hope we can understand what is happening here to make me irritated". Direct self-disclosure of countertransference feelings is often contrasted with containment of those feelings that ultimately lead to interpretation and understanding. In the reality of clinical practice, containment and self-disclosure are by no means mutually exclusive and often work together synergistically.

Countertransference has moved to the heart of psychodynamic technique. It has evolved from a narrow conceptualization of the therapist's transference to the patient to a complex and jointly created phenomenon that is pervasive in the treatment process. Much has been made about the "fit" between patient and therapist, and countertransference is largely determined by that fit.

A clinician must remember that enactments involving countertransference provide valuable information about what is being re-created in the therapeutic setting. In this regard, therapists are wise to recognize that they will be drawn into various roles in the course of the therapy, and that maintaining an artificial aloofness is neither desirable nor helpful.

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# Psychotherapy supervision: an ever-evolving signature pedagogy

Psychotherapy supervision has been rightly recognized as one of the key signature pedagogies of psychiatry and other mental health disciplines[1]. Signature pedagogies refer to those characteristic forms of teaching and instruction that organize how future practitioners are educated with regard to three dimensions of professional work: to think, perform, and act with integrity[2].

Psychotherapy supervisors foster development of treatment-facilitative habits of head (knowledge), habits of hand (skills), and habits of heart (attitude/values). Much as clinical rounds serve as the signature pedagogy for medical education, psychotherapy supervision serves as the signature pedagogy for psychotherapy education.

Since its formal inception nearly a century ago, supervision has been increasingly recognized as highly important for, even *sine qua non* to, the optimal learning of psychotherapy. Nagging, inhibiting myths about its practice (e.g., "If I have experienced supervision as a supervisee, then I am qualified to be a supervisor") have been exposed as erroneous, and a guiding ethos of supervision as a competency-based, evidence-based area of practice in its own right has emerged prominently[3]. Perhaps supervision's current status and future directions might best be captured by means of the following ten points.

First, although a host of supervision definitions has been put forth, they all converge on some core features. Psychotherapy supervision typically involves senior, professionally approved supervisors formally providing relationship-based, treatment-focused psychotherapy education and training to junior colleagues/trainees about their ongoing therapeutic work[4,5].

Second, supervision's primary purposes are: developing and enhancing supervisee conceptual/treatment skills; developing and crystallizing the supervisee's sense of identity as a psychotherapist; developing the supervisee's conviction about the meaningfulness of psychotherapy itself; and monitoring supervisee treatment efforts and safeguarding patient care[1,4,5]. Thus, supervision is fundamentally normative (assuring quality control), formative (facilitating supervisee development), and restorative (encouraging supervisee emotional processing and attending to supervisee well-being).

Third, the primary perspectives of supervision practice are psychotherapy-focused, developmental, and social role/process[1,4,5]. Psychotherapy-focused supervision perspectives are oriented around a particular form of psychotherapy and its learning; the supervision process is uniquely stamped by the psychotherapy being learned. Developmental supervision perspectives give focus to the developmental stages and issues that define the growth experience of the evolving therapist and the supervisor's facilitative responsiveness to the developing supervisee. Social role/process perspectives place focus on supervisees' evolving learning needs and the supervisor roles that most responsively match those evolving needs.

Fourth, the chain of change in psychotherapy supervision follows a logical progression. Through meeting and melding of their person/personhood, supervisor and supervisee build a constructive supervisory relationship, that makes supervisor intervention possible, that then contributes to supervisee development, that then accordingly contributes to patient development[6,7]. Each variable in the chain builds on and is made a more likely reality by its predecessor's realization.

Fifth, all supervision perspectives have come to increasingly grant primacy of place to the supervision relationship. This is now